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ABSTRACT

An attempt was made to study the influence of social networks in Sri Lanka by identifying, selecting, and training volunteers to serve as informal educators of their own social networks. These educators who each were to serve a cluster of 20-25 families were young adults; the majority were females linked to health, education, or community development staff and institutions. The pattern of health care use within the small population units was observed. The process of seeking care seemed to be mediated by an amorphous system of advisors, providers, and supporters within the immediate family and significant others within the family cluster--with females and males playing distinct roles. After a three-month training period, the volunteers were studied through longitudinal surveys as they tried to improve the quality and quantity of interaction within the families to promote better health care. It was found that the volunteer health worker system for education and intervention provided a mechanism to grasp latent opportunities within communities to bring about changes in health behavior. The value systems within different organizational contexts were reflected in the performance of the volunteers; the health-linked volunteers demonstrated the clinic approach in immunization and antenatal care, while organizational activities were highlighted by volunteers linked to the community development system. The school system seemed to nurture the self-care role best and to be even more effective than the formal health care system in the promotion of preventive care. The study suggested that a group of young, predominately female volunteers can be effective in promoting health care in countries like Sri Lanka where a preponderance of educated youth live. (KC)

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Presentation Abstract

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Social Networks as a Mode of Informal Learning in Health Care - Comparison of Networks in Three Systems: Health, Education and Community Development.

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In developing countries tradition changes rather slowly, especially with regard to health among rural populations, where the gap in knowledge, modern technology and health practices are at their widest. In this situation interpersonal influence and social networks form critical variables in the utilization of resources, and adoption of health practices.

Within this theoretical framework, an attempt was made to study the influence of social networks in Sri Lanka, a buddhist island Republic, which is mainly rural with 20,000 small villages and a population of 15 million. The adult health education program was to identify, select and train suitable volunteers to serve as informal educators of their own social networks. These educators each serve a cluster of 20 - 25 families with a population unit of about a hundred persons. The volunteers who were young adults (18-30 years), composed of a majority of females (2 females : 1 male) were linked to health, education and community development staff and institutions.

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SOCIAL NETWORKS

The utilization of social networks to permeate and influence the behaviors of groups is neither new nor is it likely to be exhausted as an intervention strategy in the future. What is perhaps new in this social experiment is that adult educators were generated within socially defined and geographically demarcated units. These change agents were not essentially from the elite and older leadership ("opinion leaders")(2) but were from the relatively younger more educated and middle level leadership groups, with formal or informal links to the leadership and closer ties with those most in need of the educational and health care efforts. The identification, selection, motivation and training of this segment of catalysts and activists for health education was one of the critical areas for research and operationalization. These voluntary adult educators whose main function was to provide education in primary health care were linked to the (1) health care system, (2) school system or (3) community development organizations. The pattern of volunteer performance within these varying organizational settings in achieving health related goals illustrates the capacity and contribution which supportive organizations like the school and community developmental agencies can make when they adopt a more direct role for education in health care.

CATEGORIES OF VOLUNTEERS

V_H - Volunteer health worker (adult educators) linked to health care personnel and institutions.

V_S - Volunteer health worker linked to the school system.

V_C - Volunteer health worker linked to the community development system.

THE VOLUNTEER HEALTH WORKER

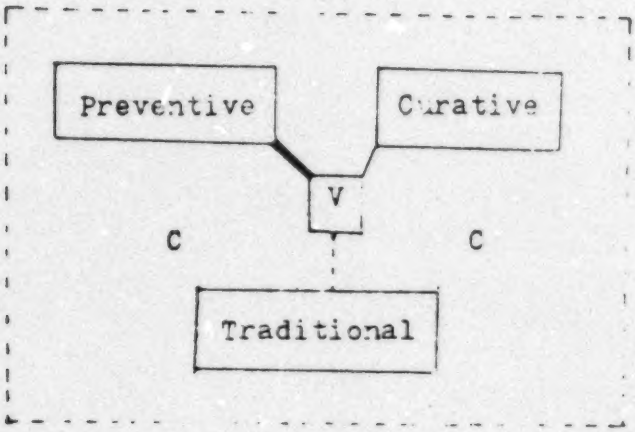
In order to educate and influence behavior within the family and communities, an examination of the pattern of health care use, and sources modifying such usage becomes essential. Rural families cluster around sources of water, agricultural activity or other common occupational persuits. Land ownership and cultivation practices often link and lock individuals and groups into patterned relationships of rights and responsibilities(3). In a number of countries industrialization and the subsequent population exodus into cities, has broken the patterned behavior in rural communities, while in others where transitional states of development exist, the links with rural origins is maintained in a less rigid manner. Sri Lanka with a high degree of female literacy (85%), educational opportunity and social mobility has yet retained a rural framework in development. There are only a few large cities, and a rural agricultural economy based on tea, rubber and rice cultivation has permitted the survival of strong links within rural

communities. Villages with a population of 500 - 1000 form the basic social unit and family clusters of 20 - 25 make up more or less discrete subunits.

LAY REFERRAL SYSTEM

The pattern of health care use within such small population units was observed and is graphically represented in Fig.1(page 5). The process of seeking care seems to be mediated by an amorphous system of advisors, providers and supporters within the immediate family and significant others within the family cluster. Family ties, work affiliations and exchange transactions of a reciprocal nature in caring seem to validate the credibility of this referral system (4). Women by nature of their caring role in rearing and looking after the sick, take precedence: and the older and more experienced members have naturally a more influential role. Men seem to have developed a secondary role in health care and have assumed leadership by their training, apprenticeship or association with traditional health care providers. The evolution of this role can be traced to magico-religious origins of treatment and care. The function is in the provision of resources to seek care and can be viewed as the removal of deterrents in seeking care. Also the physical and financial effort needed to seek care during exacerbation becomes the function of the male. This naturally occurring lay referral system with specificity for male and female roles forms the matrix from which the organized volunteer

Components of the Systems of Health Care



C - Community

V - Volunteer subsystem

Model of Lay Referral System in Sri Lanka

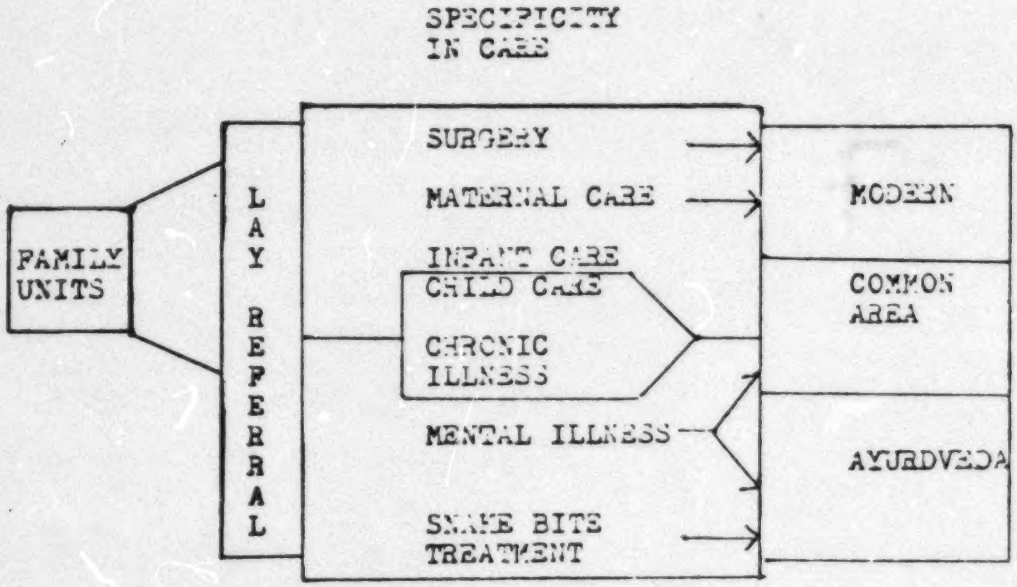


Fig 1

health worker (adult educator) was evolved. As is observed in Fig.2 (page 7) persons seek care from both the traditional and western sources of care providers, and there are common areas of care served by both systems, so that persons with affiliations to both systems would help bridge and facilitate the referral process.

VOLUNTEER HEALTH WORKER SYSTEM

To be functional the characteristics of the organized volunteer system must correspond and correlate to the major components of the lay referral system. The two major characteristics shown by members in the lay system are that of trust and expertise. Trust credibility is a function of homophily(5), the basis being the shared similarity of experiences, this being high within primary groups of friends and relatives. Expertise on the other hand is something acquired through experience or training. By suitably modifying the conditions of selection and training, the volunteer, a member of the social subunit is conferred by association and training, these dimensions of trust and expertise without sacrificing one for the other.

THE EXPERIMENT

Volunteers were identified and selected by processes tested out in pilot studies (6). Essentially they had to be part of the family clusters (20 - 25), and acceptable to the community. They were trained locally by field health personnel over a period of three months, the ratio of time spent on

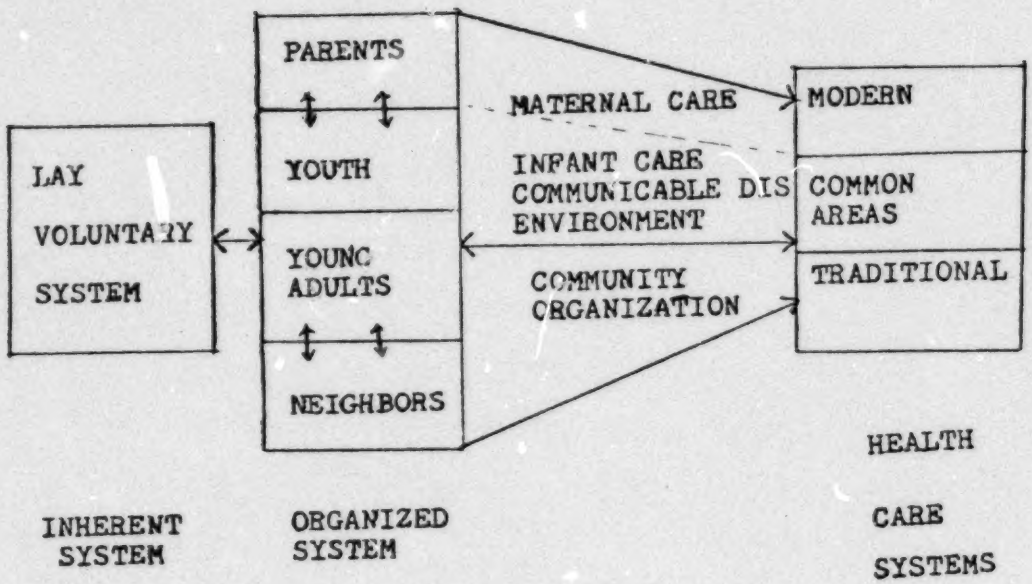

VOLUNTEER SYSTEM
ASPECTS OF CARE
PARENTS
YOUTH
YOUNG ADULTS
NEIGHBORS
LAY VOLUNTARY SYSTEM
MATERNAL CARE
INFANT CARE
COMMUNICABLE DIS
ENVIRONMENT
COMMUNITY ORGANIZATION
MODERN
COMMON AREAS
TRADITIONAL
INHERENT SYSTEM
ORGANIZED SYSTEM
HEALTH CARE SYSTEMS

Fig. 2.

formal teaching sessions to field visits and study of family and community situations was 1 : 2. As these educators lived in the village the strategy was to improve the quantity and quality of informal interactions with the families. Formal identification and clarification of health and learning needs were done through surveys, using simple diagnostic instruments carried out jointly by health staff and volunteers. The primary sensors for the educational and health needs were the volunteers themselves. The greatest advantage was that when illness or other health related event occurred these persons who lived within the community were able to advise and assist almost immediately.

Volunteers were usually linked to (1) the health worker (midwife / sanitarian) and to a clinic, while in those areas where such opportunities did not exist they were linked to (2) a school and teachers and (3) community development center and community development staff. In each of these geographical areas there were also volunteers who had minimal contact with the personnel or institution concerned. They were termed non-linked volunteers. These naturally occurring events provided the design for the experiment.

The performance of each of these categories (linked and non-linked) in the three systems was studied through longitudinal surveys and results are shown graphically in Fig.3,4,5,6 and 7.

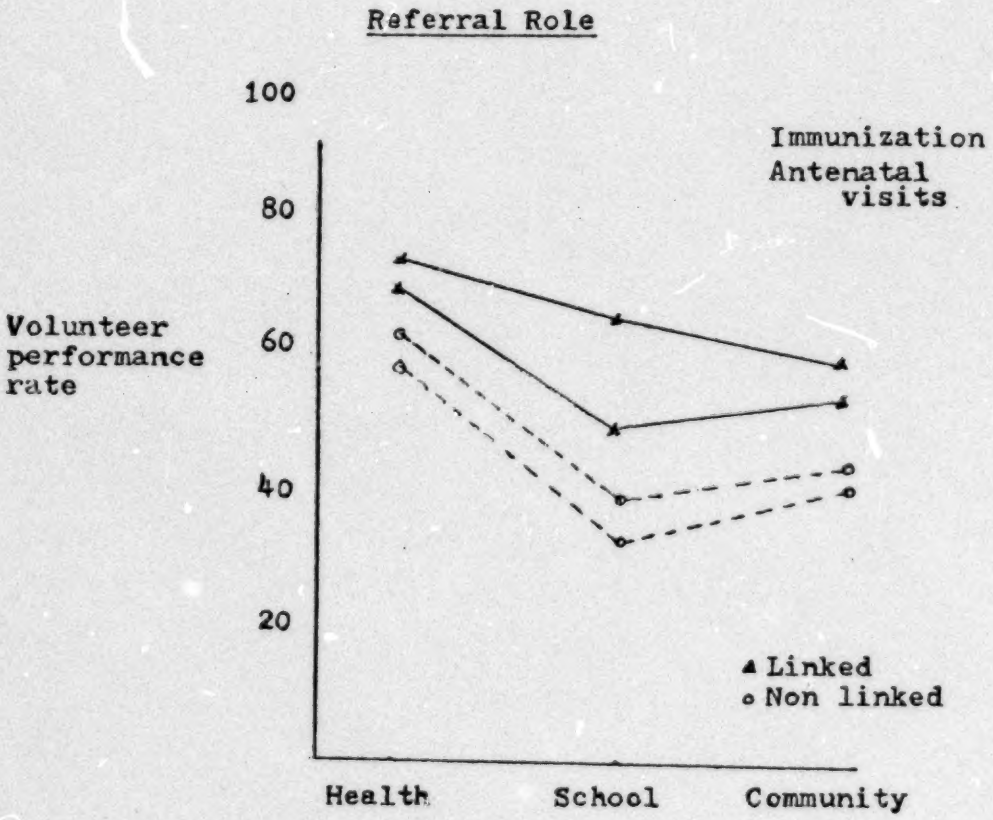

Referral Role
100
80
60
40
20
Volunteer performance rate
Immunization
Antenatal visits
Linked
Non linked
Health
School
Community

Fig. 3.

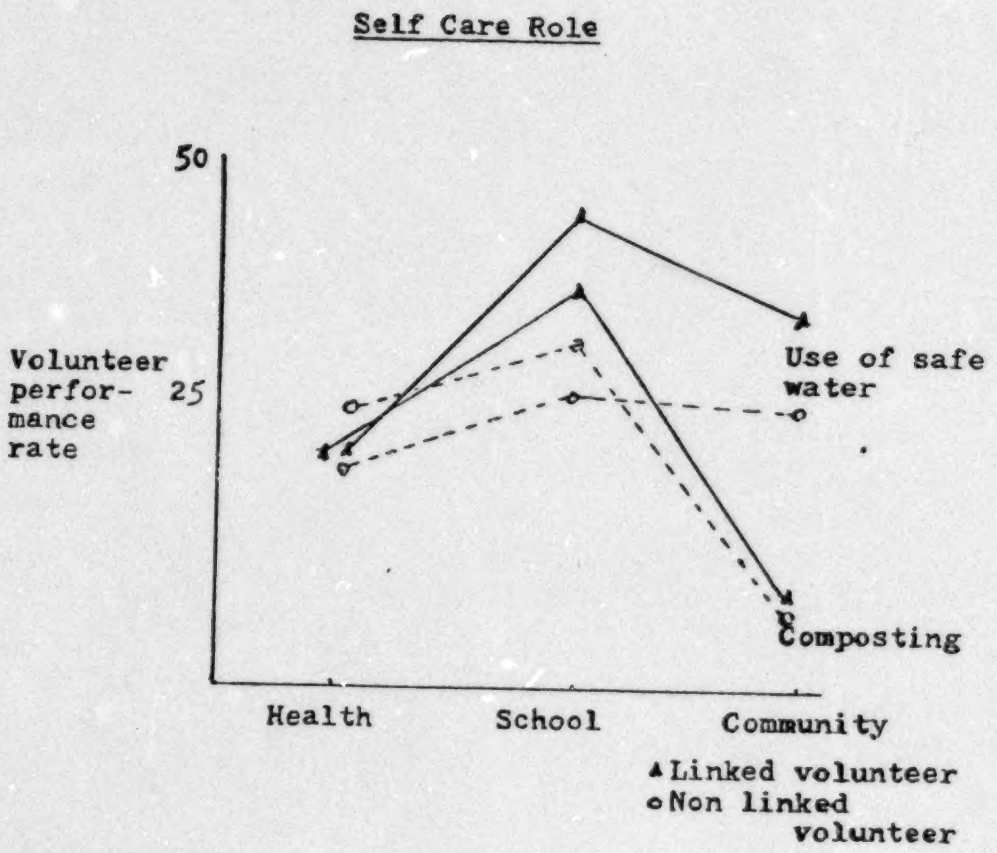

Self Care Role
50
25
Volunteer performance rate
Use of safe water
Composting
Health
School
Community
▲Linked volunteer
○Non linked volunteer

Fig. 4.

Curative and Organizer Roles

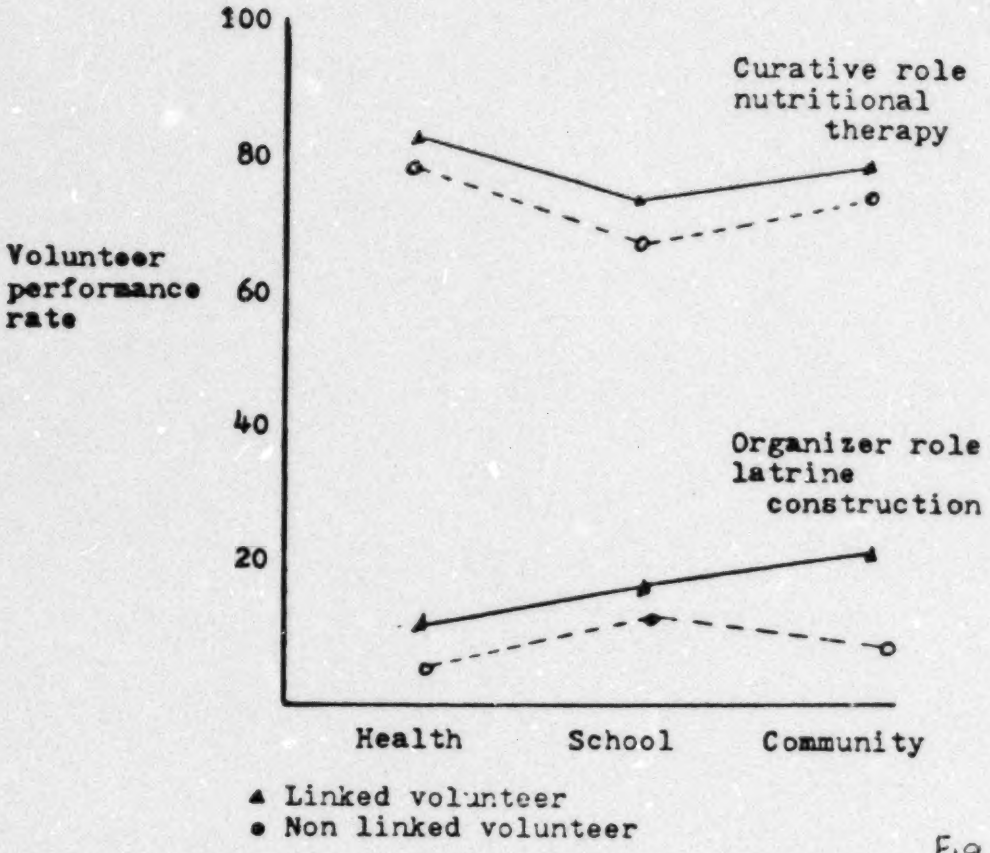


Fig 5

Referral Role

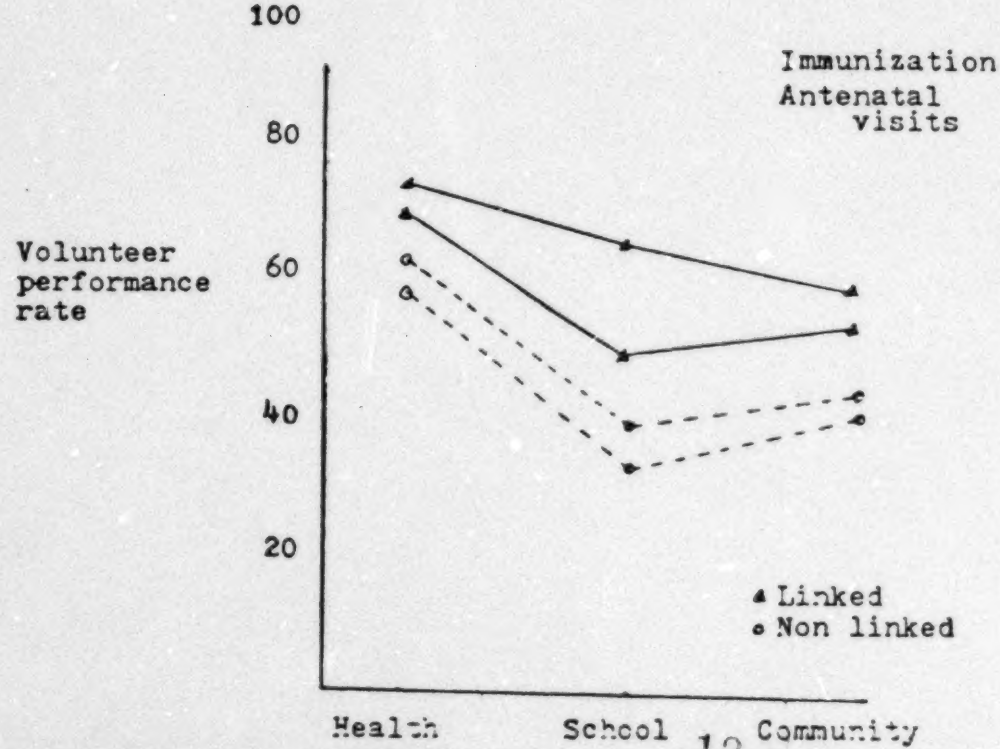


Fig. 6

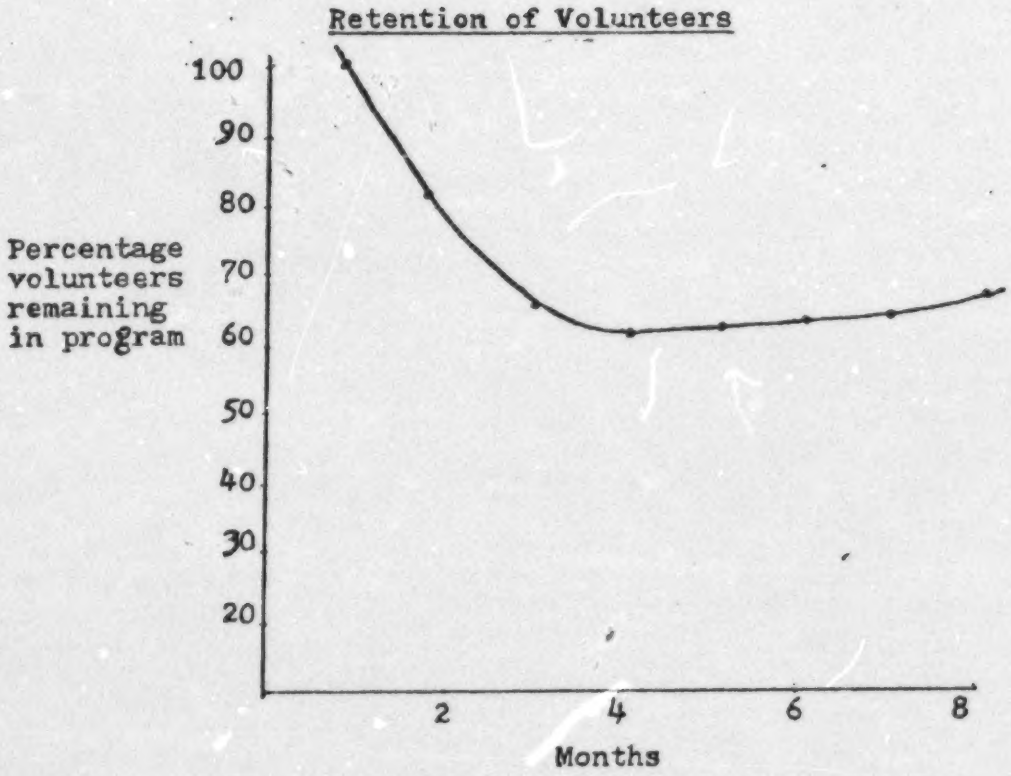

Retention of Volunteers
Percentage volunteers remaining in program
100
90
80
70
60
50
40
30
20
2
4
6
8
Months

Fig 1

RESULTS

(1) Linked volunteers performed better in each of these categories than non-linked volunteers.

(2) The performance of linked volunteers shows that $V_H > V_S > V_C$ in immunisation and antenatal care involving medical treatment processes. (values significant $p < .05$)

(3) The performance of linked volunteers in self care role shows $V_S > V_H > V_C$ demonstrating the significant role of school systems in promoting value for preventive health care.

(4) The performance of curative roles is relatively high and seems to be independent of the system within which one functions provided the demand is high.

DISCUSSION

The volunteer health worker system for education and intervention provides a mechanism to grasp latent opportunities within communities to bring about changes in health behavior. Sometimes intervention supercedes education when the curative functions of the volunteers predominate. The training model develops the treatment role only after the prevention and educational aspects are stabilised.

The value systems within different organizational contexts may be reflected in the performance of the volunteers- the health linked volunteers demonstrating the clinic approach in immunisation and antenatal care, while the organizational activities are highlighted by those in linkage with the community development system. The school system seems to

nurture the self care role best, and be even more effective than the formal health care system in the promotion of preventive care.

The composition of volunteers shows a predominance of females (2:1) and younger age groups (13-30) constitutes 80 percent. The tendency was to assume that these groups are less effective in traditional and conservative settings. Similar programs in other countries (Thailand, India) use leader type or elder volunteers. The experience in Sri Lanka was that older traditional leaders tended to maintain the status quo, and controlled the rate of change as well as the areas of change (eg. family planning). It is perhaps equally important to start with those who are amenable to change. This depends to a large extent not on the cultural context but the stage of development. When there is a critical mass of educated youth the intervention strategy attempted in Sri Lanka is feasible.

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